(2) the reasons and the need for the exceptional relief requested, including any resolution by the facility's governing body to support the reasons offered, and why such a rate increase cannot be obtained through the existing rate-setting regulations;

(3) the description of management actions taken by the facility to respond to the situation on which the exceptional relief request is based;

(4) the audited financial statement for the facility for the most recently completed facility fiscal year and financial data, including a statement of income and expenses, a statement of assets, liabilities, and equities, and a monthly facility cash flow analysis, for the fiscal year for which the exception is requested;

(5) a detailed description of recent efforts by the facility to offset the deficiency by securing revenue sharing, charity or foundation contributions, or local community support;

(6) an analysis of community needs for the service on which the exception request is based;

(7) a detailed analysis of the options of the facility if the exception is denied by the deputy commissioner; and

(8) a plan for future action to respond to the problem.

(c) The facility shall provide other information requested by the deputy commissioner in order to evaluate the request. If a facility fails to supply the requested information within a reasonable period, the deputy commissioner, in his or her sole discretion, will deny the request.

(d) The deputy commissioner may, in his or her sole discretion, use any information available in department records to evaluate the request. The deputy commissioner shall provide copies of the additional material to the facility upon request of the facility.

(e) The deputy commissioner may, in his or her sole discretion, request recommendations from the commission on a facility's application for exceptional relief. The deputy commissioner may, in his or her discretion, consider any recommendations made by the commission.

(f) Notwithstanding 7 AAC 43.670 — 7 AAC 43.709, the deputy commissioner of the department may, in his or her sole discretion, increase the prospective payment rate, by all or part of the facility's request, if the deputy commissioner finds by clear and convincing evidence that the rate established under the methodology in 7 AAC 43.676 — 7 AAC 43.691 does not allow for reasonable access to quality patient care provided by an efficiently and economically managed facility, and that the granting of an exception is in the public interest. In determining whether the exception is in the public interest, the deputy commissioner may, in his or her sole discretion, consider at least

(1) the necessity of the rate increase to allow reasonable access to quality care provided by an efficiently and economically managed facility, including any findings of the governing body of the facility to support the need;

(2) the assessment of continued need for the facility's services in the community;

(3) whether the facility has taken effective steps to respond to the crisis and has adopted effective management strategies to alleviate or avoid the future need for exceptional relief;

(4) the recommendations, if any, from the commission, regarding the facility's application for an exceptional relief;

(5) the availability of other resources available to the facility to respond to the crisis;

(6) whether the relief from an exception should have been obtained under the existing rate methodology; and

(7) other factors relevant to assess reasonable access to quality patient care provided by an efficiently and economically managed facility.

(g) The deputy commissioner may, in his or her sole discretion, impose conditions on the receipt of exceptional relief. Such conditions include

(1) the facility sharing the cost of the prospective payment rate exception granted;

(2) the facility taking effective steps in the future to alleviate the need for future requests for exceptional relief;

(3) the facility providing documentation as specified by the deputy commissioner of the continued need for the exception; or

(4) a maximum amount of exceptional relief to be granted to this facility under this section.

(h) If the deputy commissioner grants exceptional relief under this section, any amount granted may not be included as part of the base on which future prospective payment rates are determined.

(i) Exceptional relief granted under this section is effective prospectively from the date of the exceptional relief decision, and for a period of time not to extend beyond the end of the facility's rate-setting year. A facility may apply for exceptional relief in the following year by submitting a new application under (a) of this section.

(j) Notwithstanding 7 AAC 43.703, a party aggrieved by a decision of the deputy commissioner concerning exceptional relief may, within 30 days after the date of mailing of the decision to that party, request an administrative hearing to the commissioner of the department. The commissioner will consider the request for appeal as untimely filed if the commissioner has not received the request within 30 days after the deputy commissioner's mailing of the notice of the

decision to the party. The exceptional relief granted by the deputy commissioner will be effective subject to adjustment based on the decision reached by the commissioner on the appeal. A copy of the commissioner's proposed decision will be provided to the parties and the commission. (Eff. 3/13/89, Register 110)

Authority: AS 47.07.070 AS 47.07.073 AS 47.07.180

7 AAC 43.709. DEFINITIONS. In 7 AAC 43.670 — 7 AAC 43.709

(1) "adjusted admission" means an adjustment to inpatient admissions that increases the number of admissions by outpatient revenue, at the rate of one additional admission for outpatient revenue equal to the inpatient rate;

(2) "ancillary costs" means, in the long-term care rate, patient-billed charges for additional services in long-term care facilities, such as pharmacy prescriptions, specific supplies, and physician-ordered laboratory tests; specifically excluded items are general physical therapy costs, general supplies, and other items not specifically ordered by a physician;

(3) "appraisal" means the process of establishing the fair market value of an asset by a professional designated by the American Institute of Real Estate Appraisers as a member appraisal institute (MAI), or designated by the Society of Real Estate Appraisers as a senior real estate analyst (SREA) or a senior real property appraiser (SRPA); "appraisal" includes a systematic, analytic determination of the nature of property rights and investment in property and a determination of values based on a personal inspection and inventory of the property;

(4) "arm's-length transaction" means a transaction resulting from good-faith bargaining between a willing buyer and a willing seller who are not related organizations;

(5) "assets" means all economic resources of a health facility, recognized and measured in conformity with generally accepted accounting principles, including certain deferred charges that are not resources but that are recognized and measured in accordance with generally accepted accounting principles;

(6) "board-designated assets" means assets that have been designated or appropriated by the governing board of a facility for special uses and not for facility operations;

(7) "budget" and "budgeting" mean the financial data for, and the process of, developing a budget for annual submission to the department, by a facility receiving payment from the division of medical assistance, to support the projected prospective payment rates for the facility's fiscal year;

(8) "charges" means amounts that patients are billed for health care services provided by a facility;

(9) "commingled" funds means cash or cash equivalents, including restricted funds and board-designated assets which are accumulated in the same physical account as general operating cash or cash equivalents;

(10) "division of medical assistance" means the division within the Department of Health and Social Services responsible for administering the Medicaid and General Relief Medical assistance programs;

(11) "depreciation" means the systematic distribution of the cost or other base of a tangible asset over the estimated useful life of the asset;

(12) "donated asset" means an asset that the facility acquired nominally or with no payment in the form of cash, property, or services;

(13) "effective date" means the date on which a new or modified prospective payment rate is determined by the department to be effective;

(14) "employee benefits" means operating costs that include FICA; ESC; group health insurance; group life insurance; pension and retirement; worker's compensation insurance; and non-payroll-related employee benefits such as employee discounts, employee health centers, and child centers;

(15) "facility" means an acute care hospital, specialty hospital, skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, rehabilitation facility, inpatient psychiatric hospital facility, home health agency, rural health clinic, or outpatient surgical clinic;

(16) "fair market value" means the lesser of the appraised value or the sales price of an asset in an arm's-length transaction;

(17) "findings and recommendations" means the analysis of a facility budget or budget amendment, the resulting findings, and commission staff recommendations relating to the acceptance or modification of a facility's proposed prospective payment rates or effective dates;

(18) "fiscal year" means the operating or business year of a facility, which includes 12 consecutive calendar months;

(19) "funded depreciation" means the investment of funds generated from an allowance for depreciation plus the accumulated interest earnings;

(20) "generally accepted accounting principles" means accounting principles approved by the Financial Accounting Standard Board (FASB);

(21) "general mailing list" means a mailing list maintained by the commission consisting of all persons who have requested in writing to be included on the list;

(22) "goodwill" means the advantage or benefit acquired by a facility beyond the mere value of the capital, stocks, funds, or property it holds, as a result of the general public patronage and encouragement it receives from constant or habitual customers because of its local position, common celebrity, reputation for skill or affluence or punctuality, or from other accidental circumstances or necessities;

(23) "historical cost" means the actual cost incurred in acquiring and preparing an asset for use;

(24) "intermediate care facility" means a licensed facility certified to deliver intermediate care services as defined in 7 AAC 43.185;

(25) "intermediate care facility for the mentally retarded" means a licensed facility as defined in 7 AAC 12.300;

(26) "long-term care facility" includes intermediate care facilities and skilled nursing care facilities;

(27) "manual" means the Medicaid Rate Commission Accounting and Reporting Manual, dated June 1987 and published by the department, including all reporting forms and instructions;

(28) "notify" means to place written notice of an action in the United States mail, addressed to the last known address of a person, or to deliver written notice by hand to a person;

(29) "operating lease" means a lease under which rents or lease payments are included in current operating expenses;

(30) "patient day" means a calendar day of patient care;

(31) "person" means an individual, partnership, association, corporation, facility, municipal corporation, or the state;

(32) "prospective payment rate" means the rate authorized by the department to be paid by the division of medical assistance to a facility for services provided to Medicaid and General Relief Medical assistance recipients, as described in 7 AAC 43.676;

(33) "rate" means the average revenue per defined unit of service for each revenue center identified in the manual;

(34) "related organizations" means organizations having a relationship of the sort described in sec. 267(b) and 267(c) of the U.S. Internal Revenue Code as amended by P.L. 95–628, November 10, 1978;

(35) "restricted funds" means money that by agreement with or direction of the donor is restricted in the use of its principal or interest to a specific purpose;

(36) "skilled nursing facility" means a licensed facility certified to deliver skilled nursing care services to medical care recipients, as defined in 7 AAC 12.250 — 7 AAC 12.290;

(37) "state programs" means the Medicaid and General Relief Medical assistance programs of the state;

(38) "unrestricted funds" means money that is not restricted to a specific use by the donor;

(39) "occasion of service" means adjusted admission, as applied to acute care and specialty hospitals; patient day, as applied to long-term care facilities; surgery, as applied to outpatient surgery centers; and visit, as applied to rural health clinics;

(40) "rural health clinic visit" means a face-to-face encounter between a rural health clinic patient and any health care professional whose services are reimbursed by the division of medical assistance; encounters with more than one health care professional, and multiple encounters with the same health care professional, regarding the same illness or injury, which take place on the same day and at a single location, constitute a single visit;

(41) "rural health clinic" means a facility that has filed an agreement with the Department of Health and Social Services to provide rural health clinic services under Medicaid;

(42) "outpatient surgical clinic" means an ambulatory surgical center which operates as a distinct entity exclusively for the purpose of providing surgical services to patients not requiring hospitalization;

(43) "medicaid utilization rates" means the percentage of medicaid patient days within an acute care hospital's total patient days for a fiscal year;

(44) "the state" means the State of Alaska;

(45) "commission" means the Medicaid Rate Advisory Commission;

(46) "department" means the Department of Health and Social Services;

(47) "commissioner" means the commissioner of the Department of Health and Social Services or his or her designee;

(48) "deputy commissioner" means the deputy commissioner of the Department of Health and Social Services or his or her designee;

(49) "executive director" means the executive director of the Medicaid Rate Advisory Commission or his or her designee;

(50) "base year" means the facility's fiscal year ending 12 months before the prospective fiscal year;

(51) "certificate" means a certificate of need authorized by AS 18.07.031 — 18.07.111;

(52) "terms of issuance" means the terms specified by a certificate of need describing the nature and extent of the activities authorized by the certificate;

(53) "appropriate region" means the region described in the 1991 publication of *Alaska Wage Rates for Selected Occupations*,

published by the Alaska Department of Labor, that is most applicable to a facility;

(54) "commission staff" means the staff of the department assigned to carry out the purposes of the Medicaid Rate Advisory Commission and this chapter. (Eff. 8/9/86, Register 99; am 7/4/87, Register 102; am 5/8/88, Register 106; am 6/19/88, Register 106; am 7/20/88, Register 107; am 3/16/89, Register 109; am 3/13/89, Register 110; am 8/25/89, Register 111; am 10/11/89, Register 112; am 1/18/90, Register 113; am 9/21/90, Register 116; am 8/6/92, Register 123; am 3/26/93, Register 126)

Authority: AS 47.07.070 AS 47.07.073 AS 47.07.180

Editor's notes. — Copies of the publication *Alaska Wage Rates for Selected Occupations*, adopted by reference in 7 AAC 43.709(53), may be obtained from the Department of Labor, Division of Administrative Services, Research and Analysis, P.O. Box 21149, Juneau, AK 99802, telephone number 465-4500.

Article 13. Mental Health Clinic Services

7 AAC 43.725. CONDITIONS FOR PAYMENT TO A MENTAL HEALTH CLINIC. (a) To be eligible for medicaid reimbursement, a mental health clinic must be a

(1) community mental health clinic as defined in 7 AAC 43.990; or

(2) mental health physician clinic as defined in 7 AAC 43.990 and that meets the requirements of (b) of this section.

(b) The division will reimburse for services provided by a mental health physician clinic only if the following conditions are met:

(1) services must be provided by a psychiatrist or by a mental health professional clinician working under the direct supervision of a psychiatrist;

(2) the psychiatrist operating the clinic must provide direct supervision, as defined in 7 AAC 43.990, to all service providers in the clinic and must assume responsibility for the treatment given; and

(3) necessary adjunctive treatment must be provided either directly or through a written agreement with another qualified mental health professional clinician.